[Your Full Name]
[Your Address]
[Your Phone Number]
[Your Email Address]
[Date]

[Name of Privacy Officer or Records Manager]
[Name of Healthcare Facility]
[Department]
[Facility Address]

RE: Request for Amendment of Health Information
Patient Name: [Your Full Name]
Date of Birth: [Your Date of Birth]
Patient ID/Account Number: [If known]

Dear [Name of Contact Person or Department],

I am writing to formally request an amendment to my medical records, as permitted under the HIPAA Privacy Rule (45 C.F.R. $ 164.526).

I have identified an error in my records dated [Date of Entry] created by [Name of Provider]. Specifically, the record currently states:

"[Quote the specific text you wish to change]"

This information is [choose one: incorrect / incomplete / outdated] because:

[Provide a clear and concise explanation of why the entry is wrong and what the correct information should be. Attach supporting documentation if available.]

I request that the record be corrected to reflect the following:

"[Write exactly how the information should appear]"

Please notify me in writing once this amendment has been made. Additionally, I request that this correction be shared with any individuals or entities that may have received the incorrect information, as well as any others who may rely on this information to my detriment.

If you deny this request, please provide a written explanation of the reasons for the denial and instructions on how I may file a statement of disagreement.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]